KOOTENAI MEDICAL CENTER
Coeur d'Alene, ID 83814

Patient Name: MCKEE,SHAWN

Date of Service: 06/25/2013

HISTORY OF PRESENT ILLNESS: This is a 31-year-old male patient who presents to the emergency department by ambulance with report of rapidly increasing dyspnea with a history of an upper respiratory infection previously treated with antibiotic. He was reportedly tachycardic, rate 142 en route, but his O2 saturations were 96% en route on oxygen. However, on his arrival to the emergency department bay and being taken out of the ambulance, he went out and quit breathing and he was rushed into a room where he was found not to have a pulse or breathing activity and cardiac resuscitation was immediately initiated with chest compressions. The patient has no prior history in the area and I did not have any history from the family on initial evaluation. However, when his wife came, she gave a history that he had been seen a couple of weeks prior and Lebanon, Virginia where he had gone to the hospital for shortness of breath and he was evaluated there and they apparently had recommended a CT scan. However, he was too large for their scanner table and so he had been released with antibiotics with plan to go to another hospital to obtain a CT scan, but he decided he was feeling better and did not want to do that. He subsequently moved from Virginia to here and did so by driving. A few days ago began having some increasing shortness of breath again, but last night it became more severe and he had passed out at least once according to his wife, and today he got markedly worse.

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY: None available initially, except for history of upper respiratory problems. He is a very large, obese male who weighs greater than 400 pounds according to his spouse and certainly appears in size to be over 400 pounds. On presentation, he had no pulses, no respiratory effort. Pupils had already become dilated, but were somewhat reactive.

PHYSICAL EXAMINATION:
GENERAL: He had a quick initial exam.
LUNGS: No air movement. He was being bagged initially and had cardiac compressions.
ABDOMEN: Obese.
EXTREMITIES: Obese, but no obvious acute swelling anywhere.

EMERGENCY DEPARTMENT COURSE: I immediately opted to intubate the patient, but did not require any type of paralyzation. The patient was intubated by me with an 8 tube without difficulty on first attempt, had good color change on the telemetry device and then he was actively back. Initially, he had some agonal respirations. The patient had lines established quickly. He was given IV epinephrine. He got a pulse step back briefly a couple times, but then his rhythm deteriorated. I was able to get an EKG before it deteriorated and it showed a right bundle-branch block. There were some P waves, but not entire strip. The resuscitative efforts were carried out with ongoing compressions and bagged respirations. Multiple doses of epinephrine and a blood gas obtained from the right femoral puncture that was done by me with a Betadine prep. I was able to get a blood gas which gave me electrolytes as well. The pH was 6.974, pCO2 of 67.4, pO2 of 53. The sodium was normal, potassium was 5.08, calcium 4.5, chloride 106, glucose 307. The patient had a normal _____ and hemoglobin. The patient was given bicarb x2 and ongoing epinephrine doses, but he deteriorated into a bradycardic PA rhythm. Ultrasound was placed on his chest and he had no significant cardiac contractility. No evidence of a pericardial effusion was seen. The resuscitative efforts were initiated at 9:43 at his arrival and were discontinued at 10:16 and he was in agonal rhythm at that time. The patient's labs had been drawn as part of this process and revealed a white count of 19.9, platelets 412,000. Normal hemoglobin and hematocrit. His PT and PTT were within expected limits. D-dimer was elevated at 32.6 Chemistries: Creatinine was 1.5, anion gap was 19. AST of 49, ALT of 75, myoglobin 191 and troponin 0.08.

DEFENDANT'S EXHIBIT 20 1:14CV77 12/7/15
* Refused *

EMERGENCY DEPARTMENT DIAGNOSIS: Cardiopulmonary arrest, unsuccessful resuscitative efforts with the patient being coded over 30 minutes and being urgently and early able to get the patient intubated had IV access early in his presentation. The surrounding history, his weight, and symptomatology also suggest the probability is fairly high that he had a pulmonary embolus. I discussed the patient's findings and history with Deb Wilkey, Coroner. She plans to have a POST done. I also